STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for the Investigation of Complaint(s) IN00117162, IN00118553, IN00119493, IN00118592, and IN00118596. Complaint IN00117162-Substantiated. No deficiencies related to the allegation(s) are cited. Complaint IN00118553-Substantiated. No deficiencies related to the allegation(s) are cited. Complaint IN00118592-Substantiated. No deficiencies related to the allegation(s) are cited. Complaint IN00118596-Substantiated. No deficiencies related to the allegation(s) are cited. Complaint IN00119493-Substantiated. Federal/State deficiencies related to the allegation(s) are cited at F309 and F279. Survey date(s): 11/19 & 20, 2012 Facility number: 000131 Provider number: 155226 AIM number: 100274910 Survey team:	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after December 20, 2012.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Lora Brettnacher, RN-TC Christi Davidson, RN Connie Landman, RN Diane Zgonc, RN Census bed type: SNF: 13 SNF/NF 92 Total: 105 Census payor type: Medicare: 18 Medicaid: 79 Other: 8 Total: 105 Sample: 7 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 11/27/12 Cathy Emswiller RN			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on interview and record review, the facility failed to develop a plan of care which described the services required to care for a resident with a known hip fracture for 1 of 5 residents reviewed for the development of care plans (Resident #F). Findings Resident #F's record was reviewed on 11/19/2012 at 9:40 A.M. Resident #F was admitted to the facility on 1/6/11 and readmitted on 11/16/2012. Resident #F	F0279	**F 279** It is the practice of this provider to ensure that comprehensive care plans are developed for each resident that include measureable objectives and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. **What corrective action(s) will be accomplished for those residents found to have been**	12/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	had current diagnoses which included but were not limited to cerebral vascular disease, acute kidney failure, obstructive chronic airway disease, hypertension, dementia, dysphasia, encephalopathy. Resident #F had a current care plan concern originally dated 2/1/12 which indicated he had a short term memory problem. He had another current care plan concern originally dated 2/1/2012 which indicated he had difficulty making himself understood due to aphasia. Goals for this concern included Resident #F would have adequate two way communication with staff on a daily basis. Approaches to meet this goal included being observed for changes in condition. A nurse's note dated 11/9/12 indicated Resident #F fell out of bed at 11:15 P.M. on 11/8/2012. An assessment was completed, no injuries were noted, and he denied pain at that time. The doctor was notified of this information. A nurse's note dated 11/9/12 at 8:32 P.M. indicated a Certified Nursing Assistant (CNA) notified the nurse Resident #F could not bear weight on his left leg which was unusual for him. PRN (as needed) Tylenol was given. NP #3 (Nurse Practitioner) was notified and a STAT x-ray of his left hip was ordered for		**affected by the deficient practice:** The interdisciplinary team convened and reviewed Resident F's plan of care. The resident's care plan was updated. Staff was educated regarding resident's revised plan of care and C.N.A. assignment sheets were updated accordingly. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents who fall and sustain a fracture have the potential to be affected. Resident's identified as having condition changes will immediately be subjected to an interdisciplinary team review which will include care plan review and update. C.N.A care sheets will be updated at that time as well. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** In order to correct the practice,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a suspected fracture following the fall on 11/8/2012. His left hip had minor bruising. A nurse's note dated 11/10/22012 at 12:09 A.M.(third shift) indicated Resident #F denied pain at present time. His left hip was x-rayed earlier and staff would continue to monitor. During an interview on 11/20/2012 at 2:10 P.M., LPN #4 stated, "He was not hurting that bad. I got the order for Vicodin just in case but he did not need it at the time." LPN #4 indicated after X-ray results were back he verbally told staff how to care for Resident #F. A nurse's note dated 11/10/2012 at 10:22 P.M. indicated ,"Resident hip x-ray back with results, left subcapital hip FX (fracture). (Physician named) office notified and (NP #3 named) aware, and with new orders. Resident to see orthopedics on Monday. Please manage pain with PRN medication and put heat and ICE alternate and send if change in condition to ER (emergency room.) NP did not want resident sent to ER, because they send him back. (NP #3 named) said that she would talk to MD (medical doctor). On coming nurse aware, will continue to observe."		the facility developed a new systemic protocol. Nursing will be educated on the development of care plans for residents presenting with significant changes, by the Staff Development Coordinator or designee, by December 20, 2012. All residents presenting with significant changes will have resident needs sheets immediately updated by the Unit Manager or designee to reflect the plan of care. The DNS/designee will perform weekly reviews to ensure compliance. If non-compliance is found, nurses will be subjected to immediate education and disciplinary action up to and including discharge. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** A Care Plan Review and Care Plan Updating CQI tool will be completed by the DNS or designee weekly X4, monthly X3, and quarterly, thereafter (for at least six months) or until the CQI team ensures that compliance has been achieved. If 95% compliance is not achieved then an action plan will be developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The next nurse's note dated 11/11/2012 at 6:19 A.M. (7 hours and 57 minutes after the last dose of pain medicine was administered), indicated, "Resident x- ray showed up fracture and pain medication PRN given treatment applied as ordered . . .resident was not in kind of distress through out night. f/u will continue." During an interview on 11/20/2012 at 2:15 P.M., RN #5 stated, "He was in pain but Norco (Vicodin) was not available so I gave him Tylenol. I don't think Norco in EDK (emergency drug kit)." When asked how he knew Resident #F was in pain he replied, "He can't talk .facial expressions, grimacing, hurt during care. Once we settled him-ok . Moving him hurt him." The next nurse's note dated 11/11/2012 at 9:06 P.M. indicated, "Resident resting in bed comfortable, took all medication without difficulty, and pain pill PRN give for left hip pain with effect. Resident needs extensive assistance with ADL's (activities of daily living), two to change . . Will continue to observe." During an interview on 11/19/2012 at 2:20 P.M.., The Personal Service Coordinator for the orthopedic surgeon who performed Resident #F's hip surgery stated, "He should have been sent to the hospital from the beginning. I spoke with			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Surgeon named) who was on call and another surgeon and they both said he should have been sent to ER immediately. Even if he would have came here on Monday we would have sent him to the ER. At minimum even if the ER would have sent him back they would have applied a brace stabilizer. He would not have been neglected at the ER." During an interview on 11/20/2012 at 8:50 A.M., The Executive Director was asked to provide the plan of care that was in place so the staff would know how to care for a resident with a hip fracture. The DON indicated at this time staff were immobilizing Resident #F's hip while he waited for his appointment on Monday. The DON and ADON were asked what the procedure was for the immobilization of a hip and/or what immobilization of a fx hip meant to them. The ADON indicated it was protecting the area and keeping him in bed. During an interview on 11/20/2012 at 9:00 A.M., When asked if she cared for Resident #F the weekend before he was sent to the hospital CNA (Certified Nursing Assistant) #1 replied, "I took care of him that weekend. Two of us had to turn him. I wouldn't touch him without help. It was horrifying. He was in terrible pain until the ambulance came			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and got him. The aide gave me report when I came on and she said she tried to turn him by herself and he was screaming in pain. Me and (CNA #2 named) turned him using a sheet. They were just giving him Tylenol. I asked if they would give him Hydrocodone." When asked how she positioned him when he ate she replied, "I just sat him up like normal." During an interview on 11/20/2012 at 9:15 A.M., CNA #2 stated, "No nurse told me how to turn him. We just did it that way because he hurt so bad." When asked if she sat him up to eat she indicated yes but he just nibbled but he didn't eat because he hurt to much. During an interview on 11/20/2012 at 2:15 P.M., The ED stated, CNAs are not qualified to assess pain. Pain is relative. I don't know if they told the nurse he was in severe pain." At this time the ADON, DON, and ED were asked if they had any further documentation regarding the care of Resident #F after he was suspected to have a hip fracture on 11/9/2012 and before he was sent to the ER on Monday 11/12/2012. They indicated they had nothing else. An Orthopedic Initial Consult report dated 11/12/2012 indicated Resident #F presented at the ER after sustaining injury			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to his left hip 3 days prior after a fall at the nursing facility. Pt is noted to have the following injuries: Left femoral neck fracture, 100% displaced. Recommended treatment: Hemiarthoplasty. Surgery planned for tomorrow. Orders included admit to hospital, plan on surgery tomorrow,with hemiarthroplasty if cleared, left lower extremity non-weight baring, Bucks traction, pre-op work up and nothing by mouth after mid-night. Resident #F had left hip surgery, recovered in the hospital, and was returned to the facility. This Federal tag relates to Complaint IN00119493 3.1-35(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on interview and record review, the facility failed to provide the necessary care and services for a resident with a know hip fracture with severe pain for 1 of 5 residents reviewed for quality care and services provided (Resident #F). Findings: Resident #F's record was reviewed on 11/19/2012 at 9:40 A.M. Resident #F was admitted to the facility on 1/6/11 and readmitted on 11/16/2012. Resident #F had current diagnoses which included but were not limited to cerebral vascular disease, acute kidney failure, obstructive chronic airway disease, hypertension, dementia, dysphasia, encephalopathy, and dysphagia. Resident #F had a current care plan concern originally dated 2/1/12 which indicated he had a short term memory problem. He had another current care plan concern originally dated 2/1/2012 which indicated he had difficulty making	F0309	**F 309** **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** It is the practice of this provider to ensure that each resident must receive necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident F was reassessed for pain and the provision of necessary services upon return from the hospital. The Resident's clinical record was reviewed and resident's plan of care was updated accordingly.	12/20/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	himself understood due to aphasia. Goals for this concern included Resident #F would have adequate two way communication with staff on a daily basis. Approaches to meet this goal included being observed for changes in condition. A nurse's note dated 11/9/12 indicated Resident #F fell out of bed at 11:15 P.M. on 11/8/2012. An assessment was completed, no injuries were noted, and he denied pain at that time. The doctor was notified of this information. A current physician's order originally dated 2/24/12 and on the current November 2012 physician's order recapitulation indicated Resident #F was to be administered Acetaminophen 2 Tablets of 325 Milligrams (MG) as needed every 4 hours for mild pain. A nurse's note dated 11/9/12 at 8:32 P.M. indicated a Certified Nursing Assistant (CNA) notified the nurse Resident #F could not bear weight on his left leg which was unusual for him. PRN (as needed) Tylenol was given. NP #3 (Nurse Practitioner) was notified and a STAT x-ray of his left hip was ordered for a suspected fracture following the fall on 11/8/2012. His left hip had minor bruising. Documentation was lacking of a pain assessment according to the facility's		**How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** All residents with fractures who present with severe pain have the potential to be affected by the alleged practice. These residents will be assessed by the assigned licensed nurse and their clinical records reviewed to ensure appropriate interventions are developed and implemented at the time of the known fracture. Staff will be educated by the Staff Development Coordinator or designee by December 20, 2012 on providing necessary services, documentation, and notification. **What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur** Staff will be educated by the Staff Development Coordinator or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	policy for Resident #F's pain. The Medication Administration Record indicated Resident #F received Acetaminophen (Tylenol) on 11/9/12 at 7 A.M. The MAR lacked documentation Resident #F received PRN pain medicine as indicated in the above nursing note. Documentation on the back of the MAR on 11/9/2012 at 7:00 A.M., Resident #F was administered Acetaminophen (Tylenol) for "pain in leg" and results effective. An un-timed entry for 11/9/12 indicated he was administered Tylenol for complaints of hip pain and results were effective. The Tylenol order was ordered for mild pain. Documentation was lacking of a pain assessment per the facility's policy. A nurse's note dated 11/10/22012 at 12:09 A.M.(third shift) indicated Resident #F denied pain at present time. His left hip was x-rayed earlier and staff would continue to monitor. The next nursing note was dated 11/10/2012 at 4:47 P.M.. This note indicated, "Resident with new order: hydroco/acetamin 5/325 mg (Vicodin) 1 tab every 4 hours by mouth as needed. May get first dosage from EDK (emergency drug kit). New orders noted and State Guardian aware. This note was		designee by December 20, 2012 on providing necessary services, documentation, and notification. Every resident identified as having a fracture will be assessed and their clinical record subjected to an update and review by the Unit Manager or designee, to ensure that necessary care and services are provided. Unit Manager or designee will update C.N.A assignment sheets accordingly. The DNS/designee will monitor the provision of care, to include daily monitoring of the MAR, for all residents who have a fracture. The DNS/designee will ensure pain assessments are accurate and complete, and that care plans/care sheets have been updated to accommodate the change of condition. This will be accomplished by observing, assessing, and interviewing the resident. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place** A Care Plan Review and Care Plan Updating CQI tool will be completed by the DNS or designee weekly X4, monthly X3, and quarterly, thereafter (for at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	entered by LPN (Licensed Practical Nurse) #4. From 11/10/2012 at 12:09 A.M. to 11/20/2012 at 4:47 P.M. (16 hours and 38 minutes) documentation was lacking of Resident #F being assessed for pain per the facility's policy. During an interview on 11/20/2012 at 2:10 P.M., LPN #4 stated, "He was not hurting that bad. I got the order for Vicodin just in case but he did not need it at the time." A nurse's note dated 11/10/2012 at 9:00 P.M. indicated Resident #F was given PRN Tylenol for pain and he would continue to be observed. Documentation was lacking of a pain assessment per the facility's policy. A nurse's note dated 11/10/2012 at 10:22 P.M. indicated ,"Resident hip x-ray back with results, left subcapital hip FX (fracture). (Physician named) office notified and (NP #3 named) aware, and with new orders. Resident to see orthopedics on Monday. Please manage pain with PRN medication and put heat and ICE alternate and send if change in condition to ER (emergency room.) NP did not want resident sent to ER, because they send him back. (NP #3 named) said that she would talk to MD (medical doctor). On coming nurse aware, will		least six months) or until the CQI team ensures that compliance has been achieved. If non-compliance is found, nurses will be subjected to immediate education and disciplinary action up to and including discharge. If 95% compliance is not achieved then an action plan will be developed. **Compliance date: 12/20/12**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	continue to observe." The next nurse's note dated 11/11/2012 at 6:19 A.M. (7 hours and 57 minutes after the last dose of pain medicine was administered), indicated, "Resident x ray showed up fracture and pain medication PRN given treatment applied as ordered . . .resident was not in kind of distress through out night. f/u will continue." This nurse's note was entered by Registered Nurse (RN) #5. Documentation was lacking of a pain assessment per the facility's policy.. The MAR indicated RN #5 administered Tylenol on 11/10/1012 at 11:00 P.M. for "pain" and it was effective. During an interview on 11/20/2012 at 2:15 P.M., RN #5 stated, "He was in pain but Norco (Vicodin) was not available so I gave him Tylenol. I don't think Norco in EDK (emergency drug kit)." When asked how he knew Resident #F was in pain he replied, "He cant talk .facial expressions, grimacing, hurt during care. Once we settled him-ok . Moving him hurt him." He indicated when the pharmacy arrive he administered it to him." The MAR indicated RN #5 administered Norco on 11/11/2012 at 4:00 A.M. (5 hours after Resident #F was assessed by an RN to need the stronger pain medication) for pain and it was effective.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	The next nurse's note dated 11/11/2012 at 1:02 P.M. indicated, ". . .res (resident) kept in bed this shift d/t (related to) L (left) hip fracture, writer will make appt (appointment) with Ortho Indy first thing in am. res given PRN pain medication x 2. will continue to monitor." This nurse's note was signed by LPN #7. Documentation was lacking of a pain assessment per the facility's policy. The MAR indicated RN #7 administered two doses of Norco on 11/11/2012. The MAR lacked documentation of the time the Norco was administered, a reason for the administration of the Norco, or the efficacy of the pain medication. The Narcotic sign out sheet for the Norco indicated on 11/11/2012 LPN #7 removed Norco at 9:00 A.M. and 2:30 P.M. LPN #7 was not available for an interview. The next nurse's note dated 11/11/2012 at 7:33 P.M. indicated the resident continued on an antibiotic for a urinary tract infection with no adverse effects. He would continue to be monitored. Documentation was lacking of an assessment of Resident #F's pain. The MAR and the Narcotic sign out sheet lacked documentation Resident #F received pain medicine since 11/11/2012 at 2:30 P.M. This nurse's note was signed by LPN #4.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

The next nurse's note dated 11/11/2012 at 9:06 P.M. indicated, "Resident resting in bed comfortable, took all medication without difficulty, and pain pill PRN give for left hip pain with effect. Resident needs extensive assistance with ADL's (activities of daily living), two to change . . Will continue to observe." This nurse's note was signed by LPN #4 and lacked documentation of a pain assessment per the facility's policy. The MAR and Narcotic Sign Out indicated the last dose of pain medication administered was from LPN #7 at 2:30 P.M.

The next nurse's note dated 11/12/2012 at 8:32 A.M. indicated, "Writer contacted Ortho Indy for appt with orthopedist. Physician stated to send res to ER d/t no appts available today. PCP notified, State Guardian and DNS notified. Ambulance called for transport." This note was signed by LPN #7. The MAR and the Narcotic Sign Out sheet indicated LPN #7 removed and administered Norco to Resident #F at 6:00 A.M. Documentation was lacking of a pain assessment and efficacy of the pain medication administered.

During an interview on 11/19/2012 at 11:19 A.M., The ED indicated at the time they did not question the NP's order not to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	send him out. In retrospect they should have called the medical director but nurses were trained to follow doctor's orders and they relied on them. She said not to send him out. If ordered to do something they felt was not standard practice they should have called the medical director. The medical director was very receptive to their calls and she felt she could call him any time. The DON (who was not employed by the facility at the time of this incident) indicated at this time her past experience would lead her to believe the resident would have been sent back to wait for surgery and the staff were immobilizing his fracture. During an interview on 11/19/2012 at 2:45 P.M., The ADON (Assistant Director of Nursing) stated, "The nurse called me because the Xray machine was broken. The company kept calling and reporting it was broken. It was a stat order. I would have expected it done within 4-6 hours. The nurse called me and I told him if they couldn't get it done within another hour to hour and half we would have to send him out. When we got the results the nurse told me the NP didn't want him sent out. I was shocked. This was a hip fracture. I asked him if he was sure this is what she said and he said he went back and forth with her and she			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	wanted to wait until Monday to make an appointment with Ortho Indy. We worried all weekend. If his condition would have changed, increase in pain, swelling, anything we would have sent him out." During an interview on 11/19/2012 at 2:20 P.M.., The Personal Service Coordinator for the orthopedic surgeon who performed Resident #F's hip surgery stated, "He should have been sent to the hospital from the beginning. I spoke with (Surgeon named) who was on call and another surgeon and they both said he should have been sent to ER immediately. Even if he would have came here on Monday we would have sent him to the ER. At minimum even if the ER would have sent him back they would have applied a brace stabilizer. He would not have been neglected at the ER." During an interview with the facility's Medical Director who was also the physician NP #3 worked under indicated, NP #3 was a very detailed practitioner. He had not talked to her so he did not know her thought process in the decision to not send him. He however was going to talk to her and would call me back. He stated, "General practice-I think he should- at least my gut sense of that was he should have been seen in the ER."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an interview on 11/20/2012 at 8:50 A.M., The Executive Director was asked to provide the plan of care that was in place so the staff would know how to care for a resident with a hip fracture. The DON indicated at this time staff were immobilizing Resident #F's hip while he waited for his appointment on Monday. The DON and ADON were asked what the procedure was for the immobilization of a hip and/or what immobilization of a fx hip meant to them. The ADON indicated it was protecting the area and keeping him in bed. During an interview on 11/20/2012 at 9:00 A.M., When asked if she cared for Resident #F the weekend before he was sent to the hospital CNA (Certified Nursing Assistant) #1 replied, "I took care of him that weekend. Two of us had to turn him. I wouldn't touch him without help. It was horrifying. He was in terrible pain until the ambulance came and got him. The aide gave me report when I came on and she said she tried to turn him by herself and he was screaming in pain. Me and (CNA #2 named) turned him using a sheet. They were just giving him Tylenol. I asked if they would give him Hydrocodone." When asked how she positioned him when he ate she replied, "I just sat him up like normal."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	During an observation on 11/20/2012 at 9:00 A.M., Resident #F was observed sitting in a wheel chair in his room. CNA #1 was present. Resident #F was asked if he remembered the weekend before he went to the hospital. He attempted to verbalize an answer but was unable. He just shook his head. I asked him if he had been in pain. He shook his head yes. During an interview on 11/20/2012 at 9:15 A.M., CNA #2 stated, "No nurse told me how to turn him. We just did it that way because he hurt so bad." When asked if she sat him up to eat she indicated yes but he just nibbled but he didn't eat because he hurt to much. During an interview on 11/20/2012 at 2:15 P.M., The ED stated, CNAs are not qualified to assess pain. Pain is relative. I don't know if they told the nurse he was in severe pain." When reminded the resident had a change in status because according to their nurses and their documentation Resident #F started out on Tylenol which was ordered for mild pain then required stronger narcotic pain medicine (Norco) which according to their policy was to be given for severe pain she did not have a response. At this time the ADON, DON, and ED were asked if they had any further			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	documentation regarding pain assessments, medication administration, care planning regarding the hip fracture, policies regarding fracture care, communication with the doctor about the increased pain and they indicated they had nothing else. During an interview on 11/20/2012 at 1:41 P.M., the Medical Director indicated he spoke with NP #3 and she indicated to him her thinking was he was stable, pain was controlled, and she felt because of this the ER would have sent him back to the facility. When she talked with the nursing staff she was not aware he was in a lot of pain. An Orthopedic Initial Consult report dated 11/12/2012 indicated Resident #F presented at the ER after sustaining injury to his left hip 3 days prior after a fall at the nursing facility. Pt is noted to have the following injuries: Left femoral neck fracture, 100% displaced. Recommended treatment: Hemiarthoplasty. Surgery planned for tomorrow. Orders included admit to hospital, plan on surgery tomorrow,with hemiarthroplasty if cleared, left lower extremity non-weight baring, Bucks traction, pre-op work up and nothing by mouth after mid-night. Resident #F had left hip surgery, recovered in the hospital, and was			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	returned to the facility. A current policy titled 'Pain Management' provided by the ADON (Assistant Director of Nursing) on 1/20/2012 at 1:10 P.M. indicated, "It is the policy of American Senior Communities to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being, including pain management. It is the responsibility of the facility to ensure that each resident is assessed for pain, and the efficacy of pain medication, while keeping the resident as comfortable and pain free as possible. Procedure: 1. Residents are assessed for pain upon admission, quarterly, and with a significant change in the resident's condition and/or new onset of pain. 2. The following guidelines will be used when assessing pain, using the specific pain assessment. INTERVIEWABLE RESIDENT-The pain management program will be determined based upon the resident's verbal response to the questions on the pain assessment/interviewable resident. Pain medications will be prescribed and given based upon the intensity of the pain as follows: MILD, MODERATE,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	SEVER, VERY SEVERE, HORRIBLE. NON-INTERVIEWABLE RESIDENT-The pain management program will be determined based upon staff observation of non-verbal signs of pain as follows: NON-VERBAL SOUNDS (crying, whining, gasping, moaning, or groaning). VOCAL COMPLAINTS OF PAIN (that hurts, ouch, stop). FACIAL EXPRESSIONS (grimaces, wines, wrinkled forehead, furrowed brow, clenched teeth). PROTECTIVE BODY MOVEMENTS OR POSTURES (bracing, guarding, rubbing or massaging a body part, clutching or holding a body part during movement). 3. The physician will be notified of the resident's verbal and/or nonverbal expression of pain. 4. Physician orders for pain medication will be prescribed based upon the resident's intensity of pain, for example: Tylenol for mild to moderate pain, Vicodin for severe to very severe pain. 5. Resident's receiving routine pain medication should be assessed each shift by the charge nurse during rounds and/or medication pass. 6. Documentation of administration of ordered PRN pain medication will be initialed on the front of the Medication			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155226	A. BUILDING 00 B. WING	11/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH CAPITOL NURSING & REHABILITATION CENTER	2010 N CAPITOL AVE INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Administration Record (MAR). 7. Additional information including, but not limited to reasons for administration, interventions, and effectiveness of pain medication will be documented on the back of the MAR, or on the facility specific pain management flow sheet. 8. A plan of care will be written with the initiation of pain medication and individualized to the resident, addressing potential side effects, limitations due to pain, behavioral symptoms, and alternative pain relief techniques. 9. The licensed nurse will monitor the efficacy of the analgesia and keep the physician informed of any indicators of drug or dosage change as it related to the resident's pain management. . . This Federal tag relates to Complaint IN00119493 **3.1-37(a)**			